Request for Proposals: OHB03-2

Administrative Services & Fully Insured Health Benefit Plans
Issued July 8, 2003

Addendum One

July 18, 2003

Preface

This Addendum is issued to provide all potential offerors with definitive guidance, to the extent that is possible, on the issues raised at the Offerors' Conference held on July 18, 2003. This addendum pertains to the specific RFP listed in the heading. Separate, similar addenda will be issued addressing the specific issues raised at the Offeror's Conference for the three companion RFPs discussed at the Offeror's Conference on July 18. As announced at that conference, only these answers in writing can be relied upon in preparing an offer in response to this RFP.

Please note: Supplemental Addendums (numbered sequentially: TWO, THREE, etc) will be issued and posted to the Department's web site (www.dhrm.state.us.va) if the need arises to communicate additional information to potential Offerors. It is recommended that each interested firm check the web site regularly until the date that proposals are due and contracts awarded.

NOTE: The last page to this Addendum contains a list of all firms represented at the Offerors' conference for this RFP.

Corrections

1. Section 1.1 - Replace "criterion" with "criteria".
2. Section 1.3 - Replace "includeing" with "Including".
3. Section 2.5.11 - Delete the 2.5 before interest.
4. Section 2.8 – The subset numbering 2.7.1 through 2.7.5 should be replaced with numbering 2.8.1 through 2.8.5.
5. Section 4.1.6 – Replace 20th day with 8th day.
6. Section 8.2.4 - Capitalize "Labor".
7. Section 8.9 - replace code section 2.1-377 with code section 2.2-3800.

8. Page one "**Note**" section, replace 11-35.1 with 2.2-4343.1.

Additions:

1) ADD: Attachment 3.7 – AGE/SEX SETTLEMENT REPORT

See Sample report in Appendix 7.C. Fully insured Contractors will be provided an Excel spread sheet that calculates the settlement owed/due to the Department upon award of the contract.

2) ADD: Section 3.8 – SCHEDULE OF LIQUIDATED DAMAGES

The third standard "Eligibility Files not picked up within 7 days of transfer" should read, " **Eligibility Files not picked up and loaded to Contractor's eligibility files with 7 days of transfer".**

3) ADD: Paragraph 4.1.12 - AGE/SEX SETTLEMENTS- FULLY INSURED PLANS ONLY

Fully insured plans are subject to premium adjustments based upon the demographics of their enrollees. This settlement actuarially adjusts the premiums based upon the experience of the total pool of state and TLC enrollees with 5 year age bands by gender of the enrollee and level of coverage (See paragraph 8.5.3). A sample report providing the factors is provided under Appendix 7.C.

For the state employee group, the calculations are made monthly based upon the Contractor's enrollment as of the first day of each month. The premiums paid are adjusted monthly by the settlement factors and the adjusted net premiums are paid by EDI with support documentation provided electronically around the 10th of each month of coverage.

Under the TLC program, the Contractor is required to complete the age/sex settlement for each group individually based on the prior month's net enrollment. The completed settlements, with a summary cover sheet identifying each group and the amount of settlement for each and a total, is forwarded to the Department with accompanying payment or invoice within 20 days of the last day of the coverage month.

4) ADD: Appendix 7.C – SAMPLE AGE/SEX REPORT FORM

A sample Excel form is available on DHRM's web site at this location in Addendum One.

5) ADD: Attachment 2 – Questionnaire General #7

#7. Please provide a copy of your business plan for complying with the HIPPA Security Requirements.

Questions and Answers:

1. Medical/Surgical RFP OHB03-02 requests summary pages for PCPs, Specialists and Hospitals. However, it does not give mileage criteria for Specialists. For example, 1 PCP in 5 miles and 3 PCPs in 15 miles.

   The Department's primary concern is the enrollee's access to primary outpatient and inpatient services. The requested criteria for specialists is 2 within 15 miles.

2. Medical/Surgical RFP OHB03-02: Attachment 2.IV.17. What does "passive" mean relating to the use of a network for vision and hearing?

   "Passive" means patients receive the negotiated discount when using network providers, but use of providers is not required, nor is the benefit different.

3. RFP does not mention Medicare supplemental products for Local Choice Retirees: Advantage 65 or Advantage 65 with dental/vision. Are these products omitted from this RFP? **YES**

4. Attachment 2 is not labeled as such. Please confirm that it starts with the page that is titled "COMMONWEALTH OF VIRGINIA EMPLOYEE HEALTH BENEFITS PROGRAM PROCUREMENT Statewide Self-Funded Medical Surgical Questionnaire" for the medical/surgical RFP and correspondingly in the other RFPs.

   YES, that is correct.

5. May the large reports such as Small Businesses and Businesses Owned by Women and Minorities be submitted only on CD, rather than in hard copy? **YES**

6. Can we get a month-by-month breakdown of claims and exposure data by product and or coverage for COVA Care, The Local Choice, and Retiree Coverage? **NO**

7. Can we offer alternate products to the requested PPO and HMO Coverage's? **YES**
   Is it necessary to provide a statewide program under medical--if an alternative program is being offered (i.e. ASO HMO)? **NO**

8. Can you identify any High Amount Claims and Diagnosis over $200,000? **NO**
   Please indicate if they would be considered active. **N/A**

9. Can you provide a copy of the current utilization and discount reporting for the medical program?

   Utilization is reflected in the data provided. The net payments data will not be provided. The Commonwealth is interested in your net payment projection. Also note there would be some question as to how applicable such information would be as the COVA CARE PLAN only went into effect on July 1, 2003.

10. Regarding the less than statewide self-funded plan – Why is it not guaranteed to be awarded? What are the advantages and disadvantages of having your portfolio to be less than a statewide funded plan?

    The Department would like to see fully insured and ASO offerings for each less than statewide plan. The Department believes that administrators submitting offers on both basis will submit better documented, more realistic proposals. There are no circumstances under which the Department shall be compelled to offer an ASO contract. Offerors, which submit on an ASO basis, only do so at their own risk. Offerors, which seriously wish to be part of the employee health benefits program, should make a serious effort to offer its customer, the Department, the products it solicited. The funding method, in the final analysis, will reflect the Department's determination that the plans offered, as a whole, meet the needs of the agencies and employees whom the Department serves and fit within the amounts budgeted for these purposes.

11. Is there a particular area that your health plan is specifically strong in?

    Section 2.0 of the RFP addressed the network specifications for both statewide and less than statewide plans. We will strongly consider all networks offered.

12. Is there any preference given to contractors that have a local presence in Virginia? Is there any advantage that you have seen regarding Virginia based contracts regarding claims or customer service in the local jurisdiction?

    No. However, the Commonwealth is always appreciative of any firms having operations located in Virginia that helps the local economy.

13. Section 1.1 "Purpose" ¶ 4 last sentence "The carved out benefits being procured under those RFPs will be included with all self funded medical/surgical plans offered as a result of the RFP." Please explain role of Medical Administrator in relation to other carved out plans?

    The ASO medical contractor(s) products are combined with the carve-out benefits to create the self-insured plan(s) that are offered by the Department as illustrated by the current COVA Care plan. The contractor works with the Department to develop employee communications such as the employee handbook. They also invoice the TLC groups for the monthly premiums and provide membership updates that are then used by the carve-out products Contractors.

14. Section 1.3 "General Description" last ¶ states: "This RFP also does not address coverage for Medicare Retiree benefits." Why not? How is it otherwise addressed? What is the current program?

    The Medicare Retiree supplemental plans are procured separately and operate on a calendar plan year.

15. Section 2.2.4 "Less than statewide" "Self-funded" specifications. (a) May Offerors respond to this RFP (OHB03-2) only and include Mental Health and Pharmacy in such a program? (b) If so, may all these benefits (medical, mental health and RX) offer a "distinctive choice"?

    (a) Offerors proposing a fully insured plan must include dental, mental health, and prescription drug components. The Department will provide those components for ASO medical plans from the ASO contracts pertaining to the individual products.
    (b) Yes

16. Section 2.3.3 "…Provider network" refers to a requirement for "local networks" to have "capitated rates." Please clarify and specify services to be capitated.

    Capitated is not used in the normal insurance sense in this case. Capitated is used to mean a schedule of professional services allowances such as those requested on Schedule 2-4 of Attachment 2.

17. Referring to 2.4.1 "…network … access". (a) Does the current administrator meet these criteria in its PPO network? (b) If the health plan does not meet the criteria precisely will it be disqualified? (c) If a health plan has the "Certificate of Quality Assurance" is the Geo Access Report not required to be submitted with the response?

    (a) YES
    (b) NO, See (c)
    (c) The Certificate must be for the specific plan being offered. Example would be if the Certificate is for a fully insured HMO and an ASO plan is being offered, then the Certificate would not apply and a Geo Access report would need to be provided.

18. Section **2.4.6** "…network for the statewide shall provide access to participating providers outside of the Commonwealth of Virginia where desired by enrollees. Does this requirement an active enrollee who lives and/or works in Virginia to have access to providers nationwide? If so, why? If not please clarify meaning of "where desired by enrollees.." For example, can the Department at this time provide an Out of Area zip code listing?

    The primary emphasis is on those enrollees living near or in border state who wish to use providers in those border states. A qualitative statement regarding available network access should be identified for border states in the obvious populated areas (e.g., Washington D.C. and suburban Maryland; Bristol; Hampton Roads/Virginia Beach; and North Carolina and West Virginia borders). Specific zip code access may be required during negotiations.

19. Section 4.3.1 - Deliverables. Which materials must be mailed annually to member's homes vs. being available by request or on a website?

    Generally, the only required annual mailing would be the identification cards resulting from open enrollment activity.

20. Section 4.3.2 refers to "distribute ASO membership to the ASO carved-out product Contractors". Does this require Medical Administrator transmit Eligibility files to Mental Health and RX vendors? Please clarify if Dental eligibility is separate and not to be supplied by the Medical Administrator? In addition, please specify all other coordination necessary between the Medical Administrator on a less-than-statewide-basis and the vendors of the carved out programs: EAP Vendor; Mental Health Vendor (for example: Mental Health Benefits and phone number on medical ID Card.); Pharmacy Vendor (for example: Rx Benefits, PBM's group code and phone number on medical ID Card.); and Dental Vendor.

    All ASO medical Contractors have the responsibility of billing the TLC member groups that have enrollment from their plan for the premiums, receiving membership updates, and providing same to any carve-out Contractors (MISA, EAP, pharmacy drug and dental) as directed by the Department. An ASO medical Contractor on a less than state wide basis would have the same responsibilities for their enrollees as would the state wide ASO medical Contractor and would include providing other Contractor information such as benefit and contact information in the plan employee handbook and other areas as directed by the Department.

21. Why is a "separate proposal required for each plan type (PPO, HMO, etc)"? Would this entail 2 entirely separate submissions or can offers make distinctions in one response only where necessary?

    It is not the responsibility of the Department to try to determine which plan type an Offeror is addressing. To ensure the terms of your proposal are clear, separate cost exhibits and questionnaires must be submitted for distinctly different plan types (HMO vs PPO vs POS etc)

Firms Represented at the Mandatory Offerors Conference

For OHB03-2 and OHB03-3

10:00AM July 18, 2003

Anthem
BMS Consulting Inc. (Providence Inc.)
Cigna Healthcare
Delta Dental Plan of Virginia
Domion Dental Services, Inc.
Harrington
HealthPlan Holdings, Inc.
Kaiser Foundation Health Plan of The Mid-Atlantic States, Inc.
Providence Healthcare
Southern Health
United Concordia
United Healthcare of the Mid-Atlantic

SAMPLE for Appendix 7.C

Commonwealth of Virginia

Calculation of Premium Settlement

ANY - HMO **MONTH 2002**

Premium Rates

$270.00
500.00
730.00

	Age of Employee		Contracts [1] Single	[2] EE+1	[3] Family	[4] Total	Cost Units [5] Single	[6] EE+1	[7] Family
	< 30		32	12	5	49	0.27	0.90	1.39
	30 - 39		55	16	55	126	0.26	0.66	1.15
M	40 - 44		22	7	20	49	0.36	0.80	1.33
A	45 - 49		24	15	25	64	0.45	0.98	1.48
L	50 - 54		18	13	22	53	0.55	1.19	1.60
E	55 - 59		18	18	4	40	0.72	1.48	1.82
	60 - 64		9	6	1	16	1.02	2.03	2.27
	65 +		2	5	0	7	1.02	2.03	2.27
	< 30		90	27	12	129	0.63	0.86	1.15
F	30 - 39		107	28	58	193	0.57	0.78	1.16
E	40 - 44		71	38	36	145	0.62	0.87	1.30
M	45 - 49		76	22	19	117	0.69	1.06	1.48
A	50 - 54		61	21	11	93	0.82	1.36	1.72
L	55 - 59		46	19	2	67	0.93	1.70	1.97
E	60 - 64		24	2	0	26	1.03	2.08	2.08
	65 +		6	0	0	6	1.03	2.08	2.08
Total			**661**	**249**	**270**	**1,180**	413.59	272.56	357.41

[8] Active Premium	$	500,070.00	
[9] Sum of Cost Units		1,043.56	= [5] Active + [6] Active + [7] Active
[10] Active Rate per Active Cost Unit		479.20	= [8] / [9]
[11] Active Risk Equalization Factor		(0.125)	= [19] / [10] - 1
[12] Active Premium Adjustment	$	(62,508.75)	= [8] * [11]

Inactives Not Eligible for Medicare

	< 30		0	0	0	0	0.27	0.90	1.39
	30 - 39		0	0	0	0	0.42	1.21	1.39
M	40 - 44		0	0	0	0	0.75	1.84	2.19
A	45 - 49		0	0	0	0	1.33	2.85	3.29
L	50 - 54		1	0	0	1	0.86	1.89	2.06
E	55 - 59		5	3	0	8	0.91	1.89	2.10
	60 - 64		5	4	1	10	1.13	2.32	2.36
	65 +		0	0	0	0	1.13	2.32	2.36
	< 30		0	0	0	0	0.63	0.86	1.15
F	30 - 39		0	0	0	0	0.76	0.95	1.20
E	40 - 44		4	0	0	4	1.36	1.68	2.15
M	45 - 49		2	0	0	2	1.32	1.82	2.14
A	50 - 54		3	0	0	3	1.08	1.67	1.86
L	55 - 59		11	1	0	12	1.15	2.03	2.11
E	60 - 64		13	0	1	14	1.03	2.08	2.08
	65 +		0	0	0	0	1.03	2.08	2.08
Total			**44**	**8**	**2**	**54**	48.42	16.98	4.44

[13] Inactive Premium	$	17,340.00	
[14] Sum of Cost Units		69.84	= [5] Inactive + [6] Inactive + [7] Inactive
[15] Inactive Rate per Inactive Cost Unit		248.28	= [13] / [14]
[16] Inactive Risk Equalization Factor		0.689	= [19] / [15] - 1
[17] Inactive Premium Adjustment	$	11,947.26	= [13] * [16]

Total: Actives and Inactives Not Eligible for Medicare

705	257	272	1,234	462.01	289.54	361.85

[18] Active and Inactive Premium	$	517,410.00	= [8] + [13]
[19] Composite Rate	$	419.29	= [18] / [4] Total

Summary

Active and Inactive Premium	**$**	**517,410.00**
Cost Containment (2% due State)	**$**	**(10,348.20)**
Active & Inactive Risk Equalization Adjustments		**(50,561.49)**
Total Settlement Due PLAN/(CVA)	**$**	**(60,909.69)**

Less: Prior Period Adjustment

	$	**456,500.31**